Cancer Talk
Connecting with Manitoba's Health Professionals
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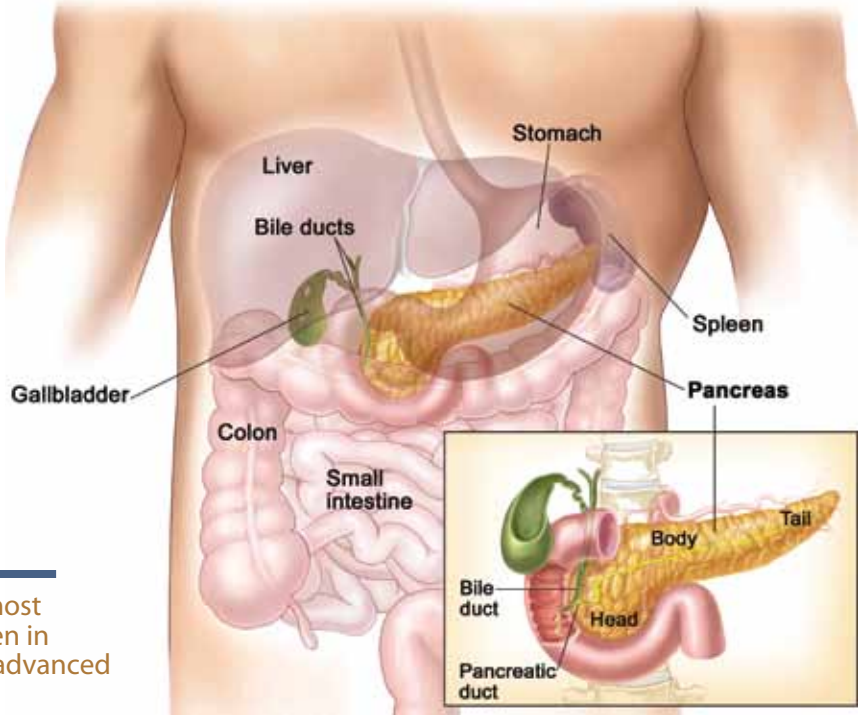
Pancreatic Cancer: Are we making a difference?

Dr. Piotr Czaykowski
Medical Oncologist, CancerCare Manitoba

Although pancreatic cancer is relatively uncommon, affecting approximately 4000 Canadians annually, it looms large because of its poor prognosis. Median survival is around one year, with age-standardized incidence rates (9 per 100,000) virtually identical to mortality rates[1]. There is no effective screening available for pancreas cancer. In more than 80% of cases the cancer is unresectable. Even with radical surgery, most patients have a recurrence within 18 months. More than 50% of patients have metastatic disease at diagnosis[2], and most patients are symptomatic with jaundice, anorexia, weight loss, pain and weakness all being common[3].



> "This is by far the most impressive gain seen in chemotherapy for advanced pancreas cancer…"

Gemcitabine became the standard of care for advanced disease in the late 1990s when it was shown to modestly prolong survival and to improve symptom control in about 25% of patients[4]. Since then, many new agents and combinations of agents have been compared to gemcitabine. Although a randomized trial has suggested that gemcitabine plus targeted therapy with erlotinib (an oral inhibitor of epidermal growth factor receptor) improves survival over gemcitabine alone, this has not been widely adopted due to the very modest gains and the significant expense and toxicity[5]. No other targeted agents has shown promise to date.

Only in the last three years has it been demonstrated that combination chemotherapy can improve outcomes in some. The **OFF** regimen (oxaliplatin, 5-fluorouracil and leucovorin) as second-line therapy after gemcitabine progression, provides tumour responses and improvement in survival[6]. The first-line **FOLFIRINOX** regimen (5-fluorouracil, leucovorin, irinotecan and oxaliplatin) has been shown to increase survival for

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Shelley Ringland RN BN MA Ed is the new Program Manager of the UPCON Program at CancerCare Manitoba replacing Pat McCormack-Speak.

Shelley had been the Patient Representative at CCMB since September 2010, was previously an instructor at Red River College, and has worked in the primary care setting at Health Sciences Centre and Children's Hospital.

Shelley is a respected nursing leader and brings great energy and clinical experience to her role with UPCON.

CCPN Educational Conference

The Community Cancer Care 2011 Educational Conference is scheduled for September 29 – Oct 1/2011 at the Victoria Inn, Brandon, Manitoba. Events include: Distress Screening Workshop, Keynote Address featuring Dr. Simon Sutcliffe, chair of the International Cancer Control Congress, Panel Sessions on Managing Advanced Cancer and Radiation Therapy and a post conference on Cancer Screening for Primary Care. http://cancercare.mb.ca/home/health_care_professionals/education_and_training/ccpn_annual_conference/

Announcing…

David Hultin, Communications & Public Affairs, CCMB

CancerCare Manitoba will soon be home to a state-of-the-art facility that will deliver world-class cancer diagnostics, treatment and research to Manitobans.

Premier Greg Selinger and Minister of Health, Hon. Theresa Oswald, announced the over $60 million investment in mid-April. The new building is planned for the corners of Olivia St. and McDermot Ave., directly across from the current MacCharles site and it will be connected via skywalk.

The structure will include two centres of excellence. One will specialize in **colorectal** cancer and be the first of its kind in Canada. The other will focus on improving the entire spectrum of care for First Nation, Inuit and Metis populations.

There will also be a centre for molecular and genetic testing that will offer counseling and advanced technologies to tailor treatments, enhancing appropriate use of leading-edge medical care.

Scholarships for Extra Training in Cancer Care

This is YOUR opportunity to pursue one to two weeks of individualized study or training related to the cancer and blood disorders. The Community Cancer Programs network (CCPN) and Uniting Primary Care and Oncology (UPCON) are pleased to offer **Community Cancer Care Scholarships** to family physicians and nurse practitioners in primary care practice who would like to enhance their knowledge and skills in order to better serve the needs of their patients. Scholarships are also available to CCPN professional staff.

Watch for the 2011-2012 application form available on www.cancercare.mb.ca at "Health Care Professionals." Application deadline October 14, 2011.

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Cancer Screening and Diagnosis: The Manitoba Picture

Roberta Koscielny, Population Oncology, CCMB

Data from CancerCare Manitoba's 2010 Community Health Assessment – a comprehensive report that examines cancer risk factors, screening participation rates, access to care and treatment, patient satisfaction and cancer trends over time - shows the overall picture of cancer care and control in the province is satisfactory, but there is room for improvement.

Awareness and participation in breast screening programs has resulted in low rates of late stage breast cancer – around 5% - and that corresponds with a survival rate approaching 90%. However, some Manitoba communities have embraced **cancer screening** more than others. Higher uptake is found in the southwest corner of the province, with lower participation in the North.

Some regions, particularly those in the north, have challenges regarding cancer control. **Late stage diagnosis** varies by region and type of cancer, but the north has the highest percentage of cancer patients diagnosed at a late stage, notably colorectal and prostate cancer, which corresponds with relatively higher cancer mortality rates.

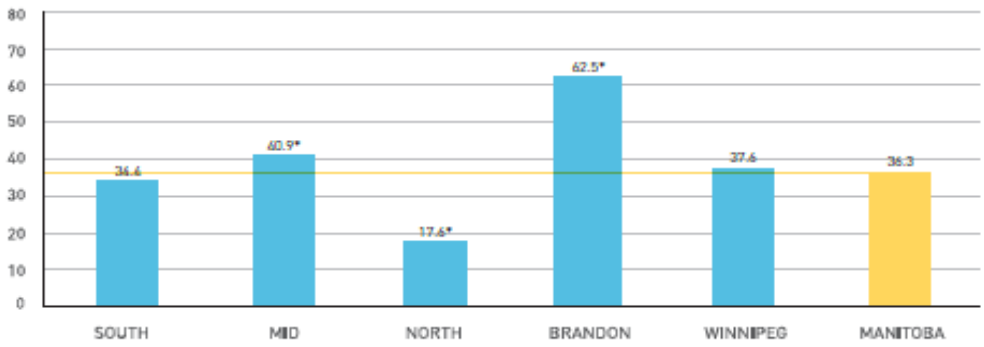
Dr. Donna Turner, an epidemiologist and CCMB's Director of Population Oncology, says challenges of geography, type of cancer and patient choice contribute to variations, however, late stage diagnosis is an overall indicator of the effectiveness of early detection and access to the cancer system.

"There is a lower proportion of late stage diagnosis in areas where screening programs have become part of the population's regular health care routine," said Dr. Turner, adding FOBT use is expected to increase as the provincial screening program expands.

Additionally, cancer **risk factors** vary considerably by region and are frequently higher in the north. If unaddressed, there could be serious implications for cancer rates and the need for service delivery in the future.

Figure 2.1

Percent of men and women (ages 50 – 74) who completed a Fecal Occult Blood Test (FOBT) in the last two years, by regional groupings



Source: Colorectal Cancer Screening: Results of a Survey of Manitobans 50 – 74. Supported by the Canadian Partnership Against Cancer and CancerCare Manitoba PRA Inc., 2008.

**Significantly different from Manitoba rate (p< 0.05).*

Ask the Cancer Expert

Dr. Marshal Pitz
Medical Oncologist
CancerCare Manitoba

Question:

"I have a 48 year old patient who was told that she has a "triple negative" kind of breast cancer, and that this is not favourable. What does this mean?"

Answer:

Triple negative breast cancers do not express the estrogen receptor (ER) or progesterone receptor (PR), and do not overexpress the human epidermal growth factor receptor type 2 (HER2) protein. They represent approximately 15% of all breast cancers. Triple negative breast cancer occurs more frequently in young black or Hispanic women and is the predominant phenotype in patients with mutation of BRCA1.

A diagnosis of triple negative breast cancer is generally less favorable than other types of breast cancer partly because of the characteristically aggressive histology. They are less likely to be detected by mammography and are often a larger size at presentation than other breast cancers. Furthermore, triple negative breast cancers have a higher tendency to recur during the first five years after diagnosis and are more likely to metastasize to brain and lung rather than bone or liver.

In addition, the lack of ER, PR, and HER2 receptors limits the therapeutic options. Anti-estrogen therapy such as tamoxifen or an aromatase inhibitor are ineffective for ER and PR negative tumours. Similarly, trastuzumab (Herceptin®), a monoclonal antibody therapy specific for the HER2 protein, is not beneficial.

These cancers may respond better to conventional chemotherapy than other forms of breast cancer. Unfortunately, this advantage does not make up for the lack of ER, PR, and HER2 directed therapies, or the underlying aggressive nature of this disease.

We've changed our names!

The CancerCare Manitoba screening programs have changed their names! Nothing else has changed - the programs continue to provide the same services.

BreastCheck
CancerCare Manitoba

Formerly the Manitoba Breast Screening Program
788-8000 | 1 (800) 903-9290

CervixCheck
CancerCare Manitoba

Formerly the Manitoba Cervical Cancer Screening Program
788-8626 | 1 (866) 616-8805

ColonCheck
CancerCare Manitoba

788-8635 | 1 (866) 744-8961

GetCheckedManitoba.ca

Treatment of Breast Cancer: The Big Picture

Dr. Chris Ogaranko, Family Physician in Oncology
Buhler Cancer Centre, Victoria General Hospital

Dr. Ogaranko and staff at the Buhler Cancer Centre, VGH

Treatment given after breast cancer surgery to reduce the risk of recurrence is called **adjuvant therapy**. The aim is to destroy any clinically inapparent micrometastses that remain following resection.

Adjuvant **chemotherapy** is generally recommended to all patients with lymph node metastases and those with tumours more than 1 cm. It is sometimes recommended to those with "node negative" disease or with smaller tumours. Patients who are medically fit and at higher risk of cancer recurrence usually receive the **FEC-D** regimen, with FEC (fluorouracil, epirubicin and cyclophosphamide) given intravenously every 3 weeks for 3 cycles, followed by docetaxel given i.v. every 3 weeks for 3 more cycles. **TC** (Taxotere/docetaxel and cyclophosphamide) is given every 3 weeks for 4 cycles to patients who are less fit or whose risk of recurrence is not as high.

Adjuvant **endocrine therapy** is offered when tumours express the estrogen and/or progesterone receptor. These medications work by preventing breast cancer cells from being stimulated by endogenous hormones. For premenopausal women, tamoxifen (which blocks estrogen receptors) is taken daily for five years. Postmenopausal patients have more choices: five years of an aromatase inhibitor (AI); tamoxifen for 2-3 years followed by an AI for a total of 5 years; or 5 years of tamoxifen followed by 5 years of an AI. The use of AIs, which decrease the production of estrogen from adrenal steroids, reduces the risk of recurrence versus tamoxifen alone in post-menopausal women. Examples include anastrozole, exemestane and letrozole. Endrocrine treatments are generally started after chemotherapy and radiotherapy are completed.

Targeted therapy with trastuzumab (Herceptin) is reserved for the 20% of patients whose tumours over-express the HER2 oncogene. This drug is usually started during chemotherapy and is given i.v. every 3 weeks for one year. It reduces the risk of recurrence and improves overall survival, but cardiotoxicity can occur, and patients undergo MUGA scans to assess left ventricular ejection fraction every 3 months.

Adjuvant! Online (www.adjuvantonline.com) is a decision making tool that helps guide treatment choices. It is available on-line after a free registration.

Cancer Care Closer to Home

Jackie Shymanski, Communications & Public Affairs, CCMB

Manitoba Premier Greg Selinger toured the Western Manitoba Cancer Centre (WMCC) in Brandon on March 21st, seeing first hand the state-of-the-art technology and facilities that will soon be available to Westman residents.

The WMCC includes a linear accelerator for radiation therapy services. Brandon will be the first city outside of Winnipeg to be able to offer residents radiation therapy, bringing care and treatment closer to home. Chemotherapy and supportive care such as pharmacy services, social work, and patient navigators, will also be available. About 300 patients will be treated at the centre each year.

The WMCC was made possible through funding from the Manitoba government and a working partnership between the Brandon Regional Health Authority and CancerCare Manitoba. The $24-million facility is anticipated to open this summer.


(from left to right): Scott Kirk, WMCC Operations Manager; Premier Greg Selinger; Drew Caldwell, MLA, Brandon East; Dr. Arnold Naimark, Vice-Chair, CancerCare Manitoba Board of Directors; Dr. Dhali Dhaliwal, President & CEO, CancerCare Manitoba

Where to find us

CCMB Referral Centre
(204) 787-2176
Fax: (204) 786-0621
M-F, 0830-1630, closed Stat Holidays
Emergency Referrals:
HSC paging: (204) 787-2071
St Boniface paging: (204)237-2053
http://www.cancercare.mb.ca

CancerCare Manitoba
Toll Free: 1-866-561-1026

Inquiry & Reception
MacCharles Unit (204) 787-2197
St. Boniface Unit (204) 237-2559

Health Records - Medico legal Correspondent:
(204) 787-2266 Fax: (204) 786-0185

Pharmacy: (204) 787-1902

UPCON Helpline (204) 226-2262

Breast Cancer Centre of Hope
691 Wolseley Street (204) 788-8080
Winnipeg, Manitoba R3C 1C3
Toll Free: 1-888-660-4866

CCMB Screening Programs
25 Sherbrook Street, Unit #5
Winnipeg, Manitoba R3C 2B1

BreastCheck
(formerly Manitoba Breast Screening Program)
(204) 788-8000
Toll Free: 1-800-903-9290

CervixCheck
(formerly Manitoba Cervical Cancer Screening Program)
(204) 788-8626
Toll Free: 1-866-616-8805

ColonCheck
(formerly ColonCheck Manitoba)
(204) 788-8635
Toll Free: 1-866-744-8961

Community Cancer Programs Network (CCPN)
(204) 787-5159
Toll Free: 1-866-561-1026

Manitoba Prostate Centre
(204) 787 - 4461
Fax: (204) 786-0637

Patient and Family Information and Resource Centre
(204) 787-4357
Toll Free: 1-866-561-1026

Patient and Family Support Services
(204) 787-2109
Toll Free: 1-866-561-1026

Patient Representative
(204) 787-2065
Pager: (204) 931-2579
Toll Free: 1-866-561-1026

Western Manitoba Cancer Centre
300 McTavish Ave. East
Brandon, Manitoba R7A 2B3
(204) 578-2222
Fax: (204) 578-4991

Other Numbers:

CancerCare Manitoba Foundation
Donations & Inquiries (204) 787-4143
Toll Free: 1-877-407-2223
Fax: (204) 786-0627

Canadian Cancer Society
Volunteer Drivers 787-4121
Toll Free: 1-888-532-6982

Cancer Information Service
Toll Free: 1-888-939-3333

Lennox Bell Lodge
(204) 787-4271
60 Pearl Street

Info for Health Care Professionals on our web site at www.cancercare.mb.ca

UPCON
Uniting Primary Care and Oncology

Pancreatic Cancer from P. 1

metastatic disease from 7 months (with gemcitabine) to 11 months. This is by far the most impressive gain seen in chemotherapy for advanced pancreas cancer, but comes at the cost of substantial toxicity (primarily myelosuppression) which limits its use to fit, minimally symptomatic patients[7].

With the improvement in chemotherapy for advanced disease, the use of "adjuvant" chemotherapy after radical surgery has also received greater attention. Randomized trials confirm that either 5-fluorouracil or gemcitabine after surgery provides a small but meaningful increase in time to recurrence. Improvement in survival has been harder to document[8,9,10]. Although adjuvant radiotherapy continues to be widely employed in the USA, its value remains debatable.

Our knowledge of the molecular underpinnings of pancreatic adenocarcinoma has grown substantially. We now recognize that is usually associated with a large number of mutations, affecting multiple critical tumor promoter and suppressor pathways[11]. Pancreatic stem cells have also been identified which may "repopulate" tumor after treatment, and explain resistance to chemotherapy and radiotherapy[12]. This knowledge is leading to a change in the direction of clinical research.

Pancreas cancer remains a sharp thorn in the sides of gastrointestinal oncologists.

1 Canadian Cancer Society's Steering Committee: Canadian Cancer Statistics 2010. Toronto: Canadian Cancer Society, 2010

2 Bilimoria et al Cancer 2007; 110: 738.

3 Horton. Curr Concepts in Oncology 1989; 1: 37

4 Burris et al. J Clin Oncol 1997; 15: 2403

5 Moore et al. J Clin Oncol 2007 ; 25 : 1960

6 Riess et al. ASCO Proceedings, 2007

7 Conroy et al. N Engl J Med 2011; 364: 1817